AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
TO Kachina Family Practice

Patient Name _____ DOB _____

Telephone: Home _____ Work _____ SSN _____-_____-_____

Address_____
(Street) (State) (City) (Zip)

Purpose of disclosure _____

I hereby authorize _____
(Company, Person, Facility)

_____
(Address: Street State City Zip)

_____ _____
(Phone Number) (Fax Number)

To release all records relative to my medical treatment and care to:

Kachina Family Practice
16611 S 40th Street, Suite 120
Phoenix, Arizona 85048
Phone (480) 706-4100
Fax (480) 706-2600

I understand that I may revoke the authorization at any time, except to the extent that action based on this authorization has already been taken. This consent will expire automatically six months from the date on which it was signed.

_____ _____
(Signature of patient) (Date)

_____ _____
(Signature of other authorized person) (Date)

_____
(Relationship to patient)

Complete and Mail or fax this form to your previous healthcare provider(s).